EXHIBIT D

HEALTH INSURANCE CLAIM FORM

AETNA USHC PO BOX 981106 EL PASO, TX 79998

APPROVIED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/08	•	gio. a					
(Lichard Manipala Michael Chi	Is. INSURED'S LD. NUMBER (For Program in Item; 4)						
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& OTHER INSURED'S POLICY OR GROUP NUMBER	a. SMPLOYMENT? (Current or Previous)	a. INEURISO'S DATE OF SIRTH SEX '					
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d. INSURANCE PLANINAME OR PROGRAM NAME	10st RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH SENERT PLAN?					
PROCURA READ BACK OF POINT BEFORE COMPLET	BIG & BIGNING THE FORML	X YES NO 5'yes, return to and complete here 9 a-d.					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize to process the claim. I shat request payment of government benefits of	the release of any medical or other information recessary her to myself or to the party who accepts assignment	payment of medical banetic to the undessigned physician or supplier to services described below.					
below. Signature on File		Signature on File					
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apply to this bill and are made a port thereof.) 350 BOU	LEVARD	1054 CLIFTON AVENUE					
JOHN CIFELLI, MD PASSAK GATE 2011 1699748	, NJ 07055	1295764661					
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HEALTH INSURANCE CLAIM FORM

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AETNA UŠHC PO BOX 981106 EL PASO, TX 79998

APPROVED BY NATIONAL UNIPORM CLAIM COMMITTEE 06/05 PICA F CHAMPYA MEDICAD OTHER TH, INSURED IS LO. NUMBER MEDICARE MEDICAD TRICARE
(Medicale 4) (Sponeore SSN) 7 (m) (For Program in Ham 1) Bennett IDE 2. PATENTS NAME (Lat Name, First Name, Middle Intital) LINELPED'S NAME (Last Harns, First Name, Middle initial) ATTENT'S WRITH DAT B. PATIENTS ADDRESS (No., Breet) AT RELATIONSHIP TO MAKERED 7. INDURED & ADDRESS (No., Steet) Bell A Spouse S. PATIENT STATUS CITY STATE STATE Olar 7 Single TELEPHONE (Include Area Code) ZIP CODE ZP COOF TELEPHONE (Include An Employed Pull-Time | Perl-Tim Student 10. IS PATIEDIT'S CONDITION RELATED TO: rt Name, Phat Name, Middle initial) IL MALERTY POLICY GROUP OF FEGA NUMBER AL OTHER INSURED/S POLICY OR GROUP MUNISGR 4. EUPLOYMENT? (Current or Previous) S. INSURED & DATE OF BRITT L_X NO YES b. OTHER DISURSOYS DATE OF SIRTH B. AUTO ACCEDENT? BHY L EMPLOYERS NAME OF SCHOOL NAME PLACE (State) FIX .u L_AJ ARS TNÓ. Ł. E. PLIPLOYER'S HAME OR SCHOOL NAME & INSURANCE RLAN NAME OR PROGRAM NAME **c.** OTHER ACCIDENTY **AETNA USHC** Мю Types 104, REBERVED FOR LOCAL USE d. INSURANCE PLAN NAME OF PROGRAM NAME 6. IS THERE ANOTHER HEALTH BENEFIT PLANT **PROCURA** X YES NO if yes, return to and complete here to a-d. 13. INSURED'S OR AUTHORIZED PERSON'S BIGNATURE I suitorize payment of medical benefits to the undersigned physician or supplier to services described below. PATIENTS OR ALTH DRACK OF PORMS SEPONE COLD. STRAGE & SEMMING THE PORMS.

12. PATIENTS OR ALTH DRAZED PERSONS SIGNATURE: I authorize the celeate of any medical or other information neous process this claim. I have request payment of government benefits either to myself or to the party who accepts assignment. Signature on File. 08 2011 Signature on File 04 OATE RIGHTO ILLNESS (Prot symptom). OR NAURY (Academ) OR PREGNANCY(LMP) HE IF PATIENT HAS HAD BANK OF SIMILAR ILLHERS. 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION A DATE OF CURRENT FROM 17, NAME OF REPERPING PROVIDER OR OTHER SOURCE HOSPITAL PATION DATES FIELATED TO CURRENT SERVICES 17b. NPI 70 19: RESERVED FOR LOCAL USE SOL OUTSIDE LAB? S CHARGE YES . NO 21. DIAGNOSIS OR NATISHE OF ELINESS OR INJURY (Relieu)
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HEALTH INSURANCE CLAIM FORM

AETNAUSHC PO BOX 981108 EL PASO, TX 70998

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE ONGS PICA PICA CHANRY STAN NO MEDICALD OTHER 14 INSURED'S I.D. NUMBER CHAMPE CHAMPIO CHAMPOON SEND (For Program in item 1) MINISTER STATE اله المختصفية) Manager (Day) (Albaicere #) X (10) ATTENT'S NAME (List Harte, First Name, Likelie Initial) ATTENT & BESTH DAT NGUMED'S NAME (Last Hame, First Name, Librida (nitet) S. PATIENT'S ADDRESS (No., Street 7. INSURADE ADDRESS NO. Spous Charl Other STATE CITY A. PATIENT STATUS CITY STATE Other X Single i.taried ZIP CODE ELEPHONE (Include Area C ZIP 00008 TELEPHONE Brickids Area Code? Employed Pul-Time Part-Time
Student Student S. OTHER NEURINOS HAVE I 10. IS PATIENT'S CONDITION PELATED TO 1. NAURODA POLICY GROUP ON PECA NURSER a. EMPLOYMENT? (Current or Provious) a. OTHER INGUISED'S POLICY OR GROUP NUMBER A INCURED & DATE OF BIRTH BEX MNO _____Y259 FX P. YELLO YCCHOEMLA D. OTHER INDURED'S DATE OF BIPITH MEX D. EMPLOYER'S NAME OR SCHOOL NAME PLACE (Glade) YYES 7 FΛ ON EL EMPLOYER'S NAME OR SCHOOL NAME e. DTHER ACCIDENTS C. INBURANCE PLAN NAME OF PROGRAM HAME YES XINO **AETNA USHC** CL INSURANCE PLAN NAME OR PROGRAM NAME 101 RESERVED FOR LOCAL USE d. 18 THERE ANOTHER HEALTH SENERT PLANT **PROCURA** 18. MRUPIDES OR AUTHORIZED PERSONS SIGNATURE I substitus payment of medical benefits to the undersigned physician or supplier is services described below. X YES NO READ BACK OF FORM BEFORE COMPLETING & GRANDS THE PORM.

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APPROVED BY NATIONAL UNIFORM CLAIM CO			EL PASO, T		
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HEALTH INSURANCE CLAIM FORM

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AETNA USHC PO BOX 981106

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE OF	EL PASO, TX	79998
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2. PATIENT'S NAME (List Home, First Harre; Alidde Initial) Officers and Different	3.PATIENTS BIATH ONTE BEX	4. INSURED'S PANE (Last Name, First Name, Midde Initial)
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PEAD BLACK OF FORM BEFORE CO. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I sut to process the cists, fater request payment of government bendow.	menut tipo a segmand thes Popes. Hoftes the release of any medical or other information deceasely ethe either to myself or to the purity who accepts seeignment	 MELITED'S OR AUTHORIZED PERBOARS SIGNATURE I subortza- payment of medical horselfs to the undersigned physician or supplier services described below.
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14. DATE OF CURRENT: XLINESS (First symptem) OR MAN DO 1 YY INJURY (Accident) OR PREGNANCY(LISP)	16. IF PATIENT HAS HAD BAVE OR SIMILAR ILLHESS. ONVE FIRST DATE MM DO	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REPERRING PROVIDER OR OTHER SOURCE	175. NPI	18. HOSPITALIZATION DATES NOLATED TO CURRENT SERVICES
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AETNA USHC PO BOX 981108 EL PASO, TX 79998

HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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HEALTH INSURANCE CLAIM FORM

AETNA USHC PO BOX 981106 EL PASO, TX 79998

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE MEDICAID	гилиро Снами		W		ts. NSUREO'S LD	NUMBER	(For	Program in Jham
(Apolicine #) [Diplomate #) (4)	Sponsor's SSM) (Mainter me, Middle Initial)	S. PATIENT & MIST					, Fini Nema, Midde	inital)
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5. PATIENT'S ADDRESS (No., Street)	,	Bell X Spouse			/ NOONED S ACC	inche filor		,
CITY	STATE	<u> </u>			CITY		······································	STATE
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ZIP CODE . TELEPH	(ONE (Include Area Code)	. — 8	id-Time (****) Parl-Ti	74	ZP CODE		LETELHONE BOT	de Area Code)
		Employed 8	tudent truden	11				
E. OTHER INSURED'S NAME (Last Martin.	Pine Name, Miccie Wille)	10.18 PATIENTS C	ONDITION RELATED	101	11, NECHEDE PO		OR PUCA NUMBER	
B. OTHER INSURED'S POUCY OR GROUP	P NUMBER	a. SMPLOYMENT?	(Current or Pyrevious)		e, INGUREDES DAT	E CHESTH		6EX
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b. OTHER MISURESTE DATE OF METH	9EX	L. AUTO ACCIDENT	Transport Control	(Caleda) B:	6. EMPLOYERS N.	WIEGRECH	COL NAME	
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C. EMPLOYER'S NAME OR SCHOOL MAM	.	COTHERN ACCIOEN	return		AETNA USHK	_	PHOGRAM PLANE	
d. Insurance plan name or progra	N NAME	10d. REBERVED PO			& IS THERE ANOT		BENEFIT PLAN?	
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Signature on File		04	08 2011			8ignature	on File	
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ALMESS OF CURRENTS ALMESS OF INJURY (AS PREGNANCE)		IF PATIENT HAS HAD GIVE FIRST DATE	MM - OR	المحب تبيد	FROM MAX	DD Y	TO	100
7. NAME OF REFERRING PROVIDER OIL		taniens (Berg		(10. HORPITALIZAT	ON DATES	BLATED TO CUEPE	NT BERVICES
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GNED DATE ICC Instruction Manual available (at: www.nucc.org	PLEASE !	PRINT OR TYP	Ē			938-0999 FORM	CMS-1500 ((

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